Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: H54244804M
Compliance #: H54247750C

Date Concluded: October 31, 2025

Name, Address, and County of Licensee Investigated:
Presbyterian Homes Arden Hills
3220 Lake Johanna Boulevard
Arden Hills, MN 55112
Ramsey County

Facility Type: Nursing Home

Evaluator's Name: Holly German, RN
Special Investigator

Finding: Not Substantiated

Nature of Investigation:
The Minnesota Department of Health investigated an allegation of maltreatment, in accordance with the Minnesota Reporting of Maltreatment of Vulnerable Adults Act, Minn. Stat. 626.557, and to evaluate compliance with applicable licensing standards for the provider type.

Initial Investigation Allegation(s):
The facility neglected the resident when he developed a stage four pressure ulcer that became infected and caused the death of the resident.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was not substantiated. The resident was independent with repositioning. The resident acquired a pressure wound on his buttocks. The facility staff properly monitored, updated the nurse practitioner (NP) with any changes and treated the wound per provider orders. The facility collaborated with dietary and physical therapy for additional interventions. When the wound worsened, and the NP failed to address concerns, the facility contacted the corporate medical director to assess the wound. The facility sent the resident to the hospital. Once at the hospital, the resident was a high-risk candidate for surgical debridement. The resident elected to have the surgery and died later at the hospital due to complications of surgery.

The investigator conducted interviews with facility staff members, including administrative staff and nursing staff. The investigator contacted family members and the resident's provider. The investigation included review of the resident records, death record, hospital records, facility incident reports, staff schedules, and related facility policy and procedures.

The resident resided in a skilled nursing facility. The resident's diagnoses included history of stroke, atrial fibrillation, chronic kidney disease, anemia, dysphagia (difficulty swallowing), and neurogenic bladder (impaired bladder nerves). The resident's care plan included assistance with toileting, transfers, and dressing. The care plan indicated the resident was oriented to person, place, time, situation, and used a power wheelchair independently. The resident was independent with repositioning.

The resident's nursing progress notes indicated a new stage two (open area with superficial skin layers) pressure wound with suspected infection was noted by staff. The note indicated the resident/responsible party, the resident's medical provider, the facility dietician, and therapy staff were all notified of the new wound.

Additional nursing progress notes from the same day indicated the facility implemented new interventions of staff assistance every three hours with turning and repositioning with the resident offloading after lunch daily. The interventions were added to the resident's plan of care.

The resident's treatment record indicated staff assisted the resident every day after lunch with offloading per the provider orders. The resident's service delivery records indicated staff assisted the resident with turning, repositioning, and bed mobility per the resident's plan of care.

The resident's clinical nutrition notes indicated the dietician met with the resident one day after the wound was noted, and educated the resident on dietary supplements to help promote wound healing, in which the resident agreed to. The note indicated the resident received double portions of protein at lunch and received a nutritional supplement, Expedite (a supplement designed to support wound healing and recovery).

A subsequent clinical nutrition note indicated the resident most often refused the nutritional supplements.

The resident's NP notes indicated the provider visited the resident and provided education to the resident on the importance of regularly getting out of his wheelchair and offloading pressure, to which the resident agreed to. The NP notes gave directive for staff to continue to cleanse the wound daily with saline and cover with a foam dressing. The note indicated the NP did not physically assess the wound during the visit.

The resident's treatment record indicated the staff completed the wound care per the provider's order.

Resident wound care assessments indicated a nurse completed a full nursing wound assessment the day the wound was noted, that included notification to the resident, the NP, dietician, and therapy department.

One week later, the next wound assessment indicated the wound increased in size. The assessment indicated the nurse updated the NP of the change. The assessment indicated the resident declined to change his bed mattress to a low air loss mattress (a specialized pressure reducing mattress) at that time.

Another week later, the resident's progress notes indicated further wound deterioration, and new treatment orders were received. The note indicated the resident requested his family not be updated on current condition. The note indicated the low air loss mattress was placed and a specialized pressure reducing cushion was placed on the resident wheelchair.

An email sent from a facility nurse to the resident's NP indicated pictures of the resident's wounds were sent and indicated the wound looked worse. The email indicated the facility nurse asked the NP for new treatment orders. The email indicated the NP responded and agreed with the treatment suggestion offered by the nurse. The NP stated in the email she would like to see the resident next week.

The next day, a facility nurse sent an email to the NP stating she thought the resident needed to have a wound debridement done, and asked the NP if she should contact a wound clinic or just continue with the current wound orders. The email indicated the NP directed the nurse to contact the wound clinic and continue the current treatment orders. The email indicated the nurse informed the NP the wound clinic stated it would take a few weeks to get the resident in for an appointment.

Four days later, an email response from the NP to the facility nurse indicated the NP did not recall talking about a wound referral for the resident but instead placed a wound referral for a different resident of the facility.

The following day, the facility's medical director assessed the resident's wound and recommended the resident be sent to the hospital for wound debridement. The next day, the resident admitted to the hospital for wound management.

Hospital records indicated the resident was high-risk candidate for surgical debridement due to chronic health conditions. The resident elected to have surgery. The resident development pneumonia after surgery. The resident passed away at the hospital 24 days later.

The resident's death record indicated the immediate cause of death as acute hypoxia (low oxygen), sepsis (total body infection), and pneumonia.

During an interview, the NP stated she routinely saw the resident every other month and as needed for acute visits. The NP stated the facility had their own wound company doctor who went to the facility for wounds. The NP stated the facility only called her as an FYI (for your information) update. The NP stated she saw the resident right around the same time she had been notified of the new wound, but did not see the wound due to the resident having visitors and did not want to get out of bed to be checked. The NP stated a nurse had told her the resident sat in his chair all day and refused to get out of his chair, so she gave an order for him to offload, but he did not want to do that. The NP stated she received an update two weeks later the wound deteriorated and a request for orders, but the facility had been communicating with their wound team. The NP stated she later found out the person she believed went to the facility to do the wounds had been on leave. The NP stated the resident was non-compliant.

During an interview, registered nurse (RN)-1 stated when wounds are noted on residents, the nurse initiates interventions, updates the provider and obtains orders, updates the resident's family or just the resident if they were their own responsible party, and communicates to staff the new changes. RN-1 stated the resident completed high level activities on his own and was his own responsible party. RN-1 stated there were times the resident declined assistance with turning and repositioning, refused supplements intended to aide in wound healing, and was not very compliant with his plan of care. RN-1 stated staff obtained treatment orders when the resident's wound was discovered and kept the resident and the NP updated. RN-1 stated they updated the resident's family when he allowed them to. RN-1 stated the wound digressed very quickly, and the facility staff wanted him to go the hospital, but the resident did not think he needed to go. RN-1 stated a new wheelchair cushion had been placed in the resident's wheelchair, an upgraded mattress had been placed on his bed, and the frequency of his turning and repositioning schedule was increased for treatment and prevention interventions. RN-1 stated many departments were involved in the care of the resident, but the resident did not want to do what was recommended for him. RN-1 stated there was no wound care team during the time the resident developed his wound, and when staff attempted to get the resident into a wound care clinic, there was not an available appointment for weeks out.

During an interview, RN-2 stated the resident declined during his stay at the facility. RN-2 stated the resident started to weaken, not eat correctly, and became dependent with transfers despite the resident believing he could do it on his own. RN-2 stated the facility monitored the resident's wound every week. RN-2 stated the resident did not eat well, and they did not get the response from the NP as fast as they wanted. RN-2 stated once the NP responded, the NP stated she wanted to come see the wound before the resident went to the hospital. RN-2 stated the NP came to the facility the next day and gave an order to send the resident to the emergency room. RN-2 stated the facility nurses treated wounds even if they had not yet received orders from the NP. RN-2 stated staff spoke to the resident often about his wound and the need to offload, but the resident wanted to stay up in his wheelchair. RN-2 stated she asked

the resident if he wanted his family updated about his wound, and the resident stated, “absolutely not.” RN-2 stated the nurse performed wound care appropriately, but they struggled to get the NP to move. RN-2 stated she believed the NP’s lack of response contributed to the digression of the wound.

During an interview, family member-1 stated the facility quickly removed therapy services from the resident and atrophied him worse. Family member-1 stated neither he nor his family were notified of the resident’s wound, and the nurse should have informed them of it during a care conference they attended, as they would have decided to have him go to a wound center at that time.

During an interview, family member-2 stated the resident could turn himself in bed with the use of railings, and it was her understanding the resident was in his chair most of the day at his computer. Family member-2 stated she did not think the resident laid down during the day. Family member-2 stated she became aware of the resident’s wound when he told her about it on the phone. Family member-2 stated she went to see the resident and the wound two days later. Family member-2 stated the resident gave her permission to take a picture of the wound, but family member-2 did not show the resident the picture because it was so bad. Family member-2 stated she called the NP the next morning but did not hear back from her nor the next day when she called again. The third day, she spoke to the NP who stated she had seen photos of the residents wound, but family member-2 was unsure the date of the photos she saw due to the lack of urgent response and lack of apparent concern from the NP. Family member-2 stated upon arrival to the emergency room, she and the resident were advised by the doctor the resident would not survive the wound. Family member-2 stated she did not believe the facility staff told the resident how bad his wound was, and did not know how the facility allowed for the wound to get so bad.

In conclusion, the Minnesota Department of Health determined neglect was not substantiated.

Neglect: Minnesota Statutes, section 626.5572, subdivision 17
“Neglect” means neglect by a caregiver or self-neglect.
(a) "Caregiver neglect" means the failure or omission by a caregiver to supply a vulnerable adult with care or services, including but not limited to, food, clothing, shelter, health care, or supervision which is:
(1) reasonable and necessary to obtain or maintain the vulnerable adult's physical or mental health or safety, considering the physical and mental capacity or dysfunction of the vulnerable adult; and
(2) which is not the result of an accident or therapeutic conduct.

Vulnerable Adult interviewed: No, deceased.
Family/Responsible Party interviewed: Yes.
Alleged Perpetrator interviewed: Not Applicable

Action taken by facility:
The facility assessed the wound, updated the resident's care plan with turning/repositioning and off-loading interventions. The facility provided wound care to the resident per provider orders. Collaborated with therapy and dietary. The facility sent the resident to the hospital.

Action taken by the Minnesota Department of Health:
No further action taken at this time.

cc:
The Office of Ombudsman for Long Term Care
The Office of Ombudsman for Mental Health and Developmental Disabilities
Minnesota Board of Nursing

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED **10/15/2025**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Presbyterian Homes Of Arden Hills	**3220 LAKE JOHANNA BOULEVARD , ARDEN HILLS, Minnesota, 55112**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
20000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: The Minnesota Department of Health investigated an allegation of maltreatment, complaint H54244804M, in accordance with the Minnesota Reporting of Maltreatment of Vulnerable Adults Act, Minn. Stat. 626.557. No correction orders are issued. The facility is enrolled in the electronic Plan of Correction (ePoC) and therefore a signature is not	20000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

Minnesota State Department of Health

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20000	Continued from page 1 required at the bottom of the first page of the State form. Although no plan of correction is required, it is required that you acknowledge receipt of the electronic documents.	20000		